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Mental health issues in Tamil refugees and displaced persons. Counselling implications

Jolanda De Vries*

Department of Psychology, Tilburg University; Research Institute Psychology & Health, LE Tilburg, The Netherlands

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Abstract

Fifty-one Sri Lankan Tamil refugees/displaced persons living in South India completed the Hopkins Symptom Checklist-58. In addition, in interviews they answered open-ended questions about personal loss, personal traumatic experiences, negative feelings, living in camps, and the availability of support. The health of the respondents was poor. Moreover, experiences such as watching the killing of family members and being wounded were mentioned as reasons to flee. Many respondents said they experienced negative feelings. Social support was reasonably available although family members were often not situated in the same camp. © 2001 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Mental health; Refugees; Displaced persons; Social support

1. Introduction

Worldwide the number of refugees still increases. In the early 1990s, there were approximately 15 million refugees [1] while in 1994 the total number had increased to 25 million [2]. Only a small proportion of the refugees seek asylum in Western countries. Most refugees just flee to neighbouring countries. For instance, during the problems in Mozambique, over 1 000 000 people fled to Malawi [3].

According to the 1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol, refugees are people who, because of a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, are outside their country of origin and are unable or, because of such fear, unwilling to avail themselves of the protection of that country. This definition, which is used in Western countries, excludes, among others, people who are displaced by violence or warfare and who have not been singled out for individual persecution. However, some governments, for instance, in most countries of Africa and Central America, recognize people as refugees whenever they have suffered violence, strife, war, and similar politically generated disasters that affect whole groups rather than in-

*Tel.: +31-13-466-2705; fax: +31-13-466-2370.
E-mail address: j.devries@kub.nl (J. De Vries).

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dividuals. The majority of the refugees under the United Nations High Commissioner for Refugees (UNHCR) mandate are persons who meet the latter definition of refugees [4].

Refugees and displaced people are very vulnerable [5,6]. They are commonly not protected by a government and they are often victims of violence in the country they fled to. Furthermore, they are seldom economically secure.

The events that refugees and displaced people faced in their home country, play a role in problems they experience when in another country. The literature on refugees living in Western countries is mainly centred around health-related problems such as post-traumatic stress-disorder (PTSD), trauma, psychosocial problems, psychological distress, depression, and somatic symptoms e.g. [7–15], stressors like assimilation, immigration, and culture shock e.g. [16–18], substance abuse e.g. [19–21], and therapy e.g. [22–27].

There are only a few studies into the mental health of refugees and displaced persons who have fled to neighbouring countries. For instance, research in a Cambodian refugee camp revealed that more than 85% of the refugees/displaced persons suffered from PTSD following an intensely traumatic event [28]. Furthermore, it was shown that psychosomatic symptoms related to depression coincided with PTSD, and that these effects could extend over a long period of time. A study among Khmer adults revealed that PTSD was positively associated with the number of traumatic events experienced [29]. In the latter study, patients with a diagnosis of PTSD reported twice as many traumatic events as those with other psychiatric diagnoses. PTSD is a delayed and/or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature which is likely to cause pervasive distress in almost anyone. In the case of refugees the stressful events are mostly 'witnessing the violent death of others' and 'being the victim of torture and/or terrorism' [30]. Mollica and colleagues [31] studied 182 Cambodian adolescents living in a refugee camp on the Thai–Cambodian border. The most frequently reported symptoms were somatic complaints, social withdrawal, attentional problems, anxiety, and depression. Others [32] studied children from Rwanda and revealed that these children had suffered inordinate and sometimes irreparable physical and psychological damage. Finally, Miller [33] examined 58 Guatemalan children living in camps in Mexico. The mental health and psychosocial development of the children appeared to be related to the physical and mental health status of their mothers.

The conflict in Sri Lanka started when the British unified the Sinhalese low country and the Tamil areas in the North-eastern part of the island into one state. The Tamils strive for autonomy, especially when Tamil is abolished as an official language in 1956. After a number of conflicts between the Sinhalese – the majority of the population – and the Tamils about the rights of the Tamils, a civil war starts which concentrates in the North-eastern part of Sri Lanka. As a result, many Tamils leave that area and flee to India or other parts of Sri Lanka. Most Tamils who left Sri Lanka are living in camps in South India. The aim of the present study was to examine the events that led to fleeing to India and the mental health (including post-traumatic stress disorder) and psychosocial problems of Tamils living in refugee camps in South India for a long time.

2. Method

2.1. Subjects

Fifty-one Sri Lankan Tamil refugees, all living in South India, participated in this study; 23 men and 28 women with ages ranging from 16 to 67 years. Of them, 47 were living in refugee camps that are spread all over Tamil Nadu, where the language is Tamil as in Sri Lanka. They all fled from the ethnic conflict in their home country. Nearly all participants had been in India for at least four years. All participants were recruited by the Organisation for Eelam Refugee Rehabilitation (OfERR), an organisation founded by refugees living outside the camps with the purpose of trying to improve the living conditions and health of the refugees living in the camps. This organization arranged meeting points with refugees for the interviews because the interviews all had to take place outside the refugee

camps. Refugees were interviewed by an Indian psychiatrist (in Tamil).

2.2. Questionnaires

All respondents were interviewed in Tamil using open-ended questions concerning the social support they received in the camps, personal traumatic experiences, loss suffered in Sri Lanka, and problems within the camps. The interviewer, who also spook English fluently, typed reports of each interview.

Furthermore, one questionnaire was administered. When possible, the refugees completed this questionnaire themselves. In the case of persons who could not read or write, the questionnaire was administered in the form of a structured interview.

Health was measured by the Hopkins Symptom Checklist [34]. This instrument was selected because the 25 item version had proven to be useful in studies with refugees from other Asian countries [29,35]. The response scale used was a five-point Likert type scale derived from the HSCL-90 [36] in order to get more differentiation in the responses. The HSCL-58 measures somatization, obsessive-compulsive behaviour, interpersonal sensitivity, depression, and anxiety. In the present study, Cronbach alphas for the scales ranged from 0.61 to 0.87. In a normative US sample average scores on the HSCL-58 were between 1.12 and 1.16 (SD's 0.24–0.28). Average normative scores for depressed neurotic persons ranged from 1.89 to 2.62 [34]. In order to measure the extent of PTSD a scale was developed consisting of items and scales from the HSCL-58 and the COPE. These items and scales were selected on the basis of the diagnostic criteria for PTSD as mentioned in the ICD-10 [30]. The selected scales were the Depression and Anxiety scales from the HSCL-58 and the Substances scale from the COPE [37,38], and several items from the HSCL-58 that are relevant for PTSD but are no part of the Depression or Anxiety scales (items 7, 9, 24, 28, 44, 47, 52, 55). The internal consistency of this PTSD scale was reasonably good (Cronbach's alpha = 0.75). The discriminant validity of the scale was supported by the finding that respondents who had experienced personal loss (other than material loss) scored significantly higher on the scale than persons who had indicated not to have experienced such losses ($t = -2.57$; $P = 0.015$).

2.3. Translation methodology

Items were translated using a forward–backward methodology. This methodology consisted of the following steps. First, a bilingual person translated the original questionnaire from English to Tamil. Subsequently, a second person translated the Tamil version back to English. Then, a third person compared the two English versions of the questionnaire to establish semantic equivalence between the versions. Finally, when items were not semantically identical, the Tamil version was adapted and again translated into English. This iterative process ended when the back-translated version was semantically identical to the original.

3. Results

3.1. Mental health issues

A substantial number of respondents scored high ($> = 3$; possible range 1–5) on the subscales of het HSCL-58. More than 10% (11.9) had somatic complaints like headaches, faintness or dizziness, pains in the heart or chest, and feeling low in energy or slowed down. Looking at obsessive-compulsive behaviour, more than one-quarter of the respondents (27.5) scored high on the respective scale. Interpersonal sensitivity, which focusses on a person's feelings of inadequacy and inferiority with respect to communicating with others, was substantially present in 19.7% of the refugees. Finally, 15.8% scored high on the Depression scale and nearly one in five (19.7) reported to be anxious. When one takes a somewhat wider perspective by looking at the number of respondents that scored 2 or more on the subscales (answering positive on all questions within a subscale, irrespective of severity), an even more serious picture emerges. More than 40% (41.4) indicated to suffer from somatic complaints. For the other phenomena, the percentages were 66.7% for obsessive-compulsive behaviour, 59% for interpersonal conflict, 58.8% for depression, and 43.2% for anxiety.

No gender differences appeared for any of the scales. These figures indicate that the health status of both male and female refugees was poor.

3.2. Post-traumatic stress disorder (PTSD)

General population studies have shown that life-time prevalence of PTSD is about 10% [39]. In the present study, 12% of het respondents scored high ($>=3$; range 1–5). This percentage was even 46 when a score of 2 or above (meaning 'a little bit to extremely') was used as the norm. There was no difference between men and women. A detailed inquiry into the kind of traumas that the refugees had experienced in their home country was made by two open-ended questions concerning personal loss and personal traumatic experiences (see Table 1). Twenty-two respondents had experienced any *personal loss*, of which nine mentioned loss of property like a house.

With regard to *personal traumatic experiences*, one-fourth of the refugees reported a critical event. A few of them had witnessed the killing of relatives. For instance, one woman told that she saw how her oldest daughter was killed by a bomb. A person who had worked in a hospital in Jaffna had witnessed how his colleagues were shot, because they were suspected of giving treatment to members of the Freedom Fighters. Five others had witnessed serious bombing by the Sri Lankan army. For example, someone had seen how the house in which more than 50 of his relatives were present at that moment, was bombed to pieces. As a result, someone mentioned still getting into a panic when hearing the sound of a helicopter. For example, one woman recollected that she and her nephew had been captured by a group of Freedom Fighters. This group told her that they had to run for their lives. When they did, the Freedom Fighters started to shoot at them. The woman got away, but her nephew, in total panic, ran towards the shooting militants. She assumed that the boy was shot dead. Another refugee told the following. A Freedom Fighter group suspected him of working for the government; so they captured him. Subsequently, he was lined up with others in an execution line. The person next to him was shot in the head which caused his brains to come out. Just at the moment that the narrator would be shot, the army came.

Apart from such events, a few respondents generated *general fears* which had made them decide to

Table 1
Events happened in Sri Lanka ($N = 51$)[a]

Event	Number of times event was mentioned
Personal loss	
Death/injury of relatives	8
Material loss	9
Husband vanished	2
Personal traumatic experience	
Death/injury of relatives	5
Shot at	1
Tortured	1
Wounded	4
Threatened	1
Forced to join a freedom group	1
General fears	
Ethnic conflict	20
Suspected of being a Freedom Fighter	1
Fear of brainwashing by Freedom Fighters	1
Threatened with removing child/relative	1
Massive rape in nearby village	1

[a] Note: Respondents could mention more than one event.

leave Sri Lanka. For instance, one person mentioned hearing about a nearby village where many women had been raped. Consequently, her father decided to go to India. In addition, many respondents indicated that the fighting between Freedom Fighters and the Sri Lankan army, the bombing, the random violence on civilians, threats and the subsequent general fear and feelings of not being safe, all summed under the heading 'ethnic conflict', were reasons for leaving their home country. Furthermore, one fourth of the respondents mentioned the death of relatives.

3.3. Negative feelings

Apart from telling about past experiences, the refugees also talked about how they felt around the time of the interview. The negative feelings mentioned are presented in Table 2. Feelings of depression, guilt, worrying, hopelessness, and helplessness were mentioned most frequently. These extreme negative feelings, assessed by the Depression scale of the HSCL-58, were connected with experiences of personal loss and traumas.

Quite a number of respondents mentioned that they worried about their relatives and friends who were still in Sri Lanka and about family members who lived in other refugee camps. Two persons did not know the whereabouts of their partner and/or relatives. This led to worrying about them. Another cause of worrying was the future. One-fifth said they felt depressed. One refugee even explicitly said that he preferred dying in Sri Lanka above staying in a refugee camp in India. Whereas five persons said they felt guilty either about having left friends behind in Sri Lanka or because they were not able to pay the funeral honours to a relative who died in Sri Lanka.

3.4. Problems within the camps

According to the respondents, a number of problems that began within the camps also attributed to their negative feelings. A sizeable number of persons mentioned alcoholism as a problem that affected camp life. Other issues raised were the gossip by women and all sorts of illegal or immoral activities. In general, these problems were attributed to living in camps which changed the social structure of life. In addition, the refugees were not allowed to work which led to a lack of money ($n = 20$) which in turn caused anguish because they could not buy things such as food and medication. The fact that children were not allowed to follow higher education was a major concern for many (former) students and their parents ($n = 16$) because in their culture education is considered very important. The whole camp situation changed social roles.

Finally, the circumstances within the camps left much to be desired. Most camps were overcrowded. For instance, the camps that are situated in cyclone shelters housed at least 100 families. Each family had some four square metres, separated from the

Table 2
Negative feelings mentioned by respondents ($N = 51$)

Feelings	Number of respondents
Worrying	17
Being depressed	11
Guilt	5
Being hopeless	3
Feeling helpless	2
Weeping	2
Suicide thoughts	2
Memories about the past	2
Upset during festival seasons	2
Distressed about events that happened in Sri Lanka	1
Not able to cope with continuing stress	1
Anxious when hearing a helicopter/plane	1
Feeling worthless	1
Fear of freedom group	1

space of other families by cotton cloth, to cook and sleep in. This housing situation was 'solved' by building straw huts outside the cyclone building. However, in the raining season, all families lived in the building making it even more crowded. This led to health problems. Furthermore, police harassment was mentioned by 11.8% of the persons, not all living in the same camp. This entailed that the police came into the camps at night demanding everyone to show their identification card in order to verify whether everyone who should be in the camp was really there. If persons were not present, their food rations were cancelled. This harassment had started after the assassination of Rajiv Gandhi by a Tamil Freedom Fighter.

Despite their problems in India, most people only wanted to go back to Sri Lanka when the fighting has stopped. Until then, they expected not to be safe in their home country. Because of the bombing and fighting and due to the fact that innocent people were still harassed by either the Freedom Fighters or the Sri Lankan army. In spite of this, some refugees, although they said that they would not be safe in Sri Lanka, had voluntarily registered to go back. They were doing this because they felt unhappy, helpless, depressed, and worried about relatives who had to stay in Sri Lanka.

3.5. Social support

Respondents were asked from which persons they got emotional support. Sixteen persons (31.4%) answered that they got support from friends and/or neighbours; one got support from elderly persons. Family members gave support to 17.6% of the respondents. It should be mentioned that some respondents received emotional support from friends/neighbours and family members. Eight persons (15.7%) said not to get any social support; for some this was by own choice. Financial help was given to 25.5% of the refugees/displaced persons; some of them received money from relatives living abroad. In a number of cases, families were separated by the Indian government. To keep in contact with relatives living in other camps was difficult, causing problems in the family. Sometimes daughters lived separately from her parents, who were not able to watch over her. In other instances the father lived in another camp, which led to changes in social roles.

3.6. Practice implications

This study shows that refugees and displaced persons have severe mental health problems. These problems may last years after fleeing the country of origin. Considering the traumas that refugees have experienced, this population needs special mental care, even when problems emerged years after they fled. It is important that clinicians are aware of the things that refugee clients might have experienced and be sensitive to problems. Usually no or hardly any attention is paid to the refugees' mental health problems because they present with all kinds of physical problems. These physical problems are then usually the focus of treatment. Traumas should be treated in stead of downplayed or disregarded as causes for present problems simply because they happened a long time ago.

(Prolonged) PTSD symptoms should initially be treated in the same way as other refugee populations with intense trauma. Such treatments should enhance feelings of control and counteracting patterns of learned helplessness [40]. Psycho-education and psycho-social activities are effective tools to alleviate traumatic stress responses. Other components of treatment can be psychological structuring of experiences, working on control, reconnecting own experiences to emotions, working on integration and future perspective, and self-help techniques [40]. Relaxation, guided meditation, communication, systematic desensitization, and behaviour prescription are possible intervention techniques [40]. In general it is important that counselling centres are easily accessible and counsellors have the same cultural background as the refugees.

4. Discussion

The mental health of the Tamil refugees/displaced persons within the present study was poor. They showed all kinds of symptoms and a considerable percentage suffered from PTSD. They had witnessed or experienced physical threat, personal loss, or had just been terrified.

Living in the camps had for the most part resolved their fears for being harmed. However, they suffered from survival guilt, grief, loss of dignity, shame, uncertainty, and other negative feelings which are known problems in refugees [5]. In addition, circumstances did not permit a normal life. They were not allowed to work or to follow higher education. The physical situation within the camps was poor. The social structure changed due to lack of normal family life caused by separation of families. Fortunately, most persons got emotional and/or material support which were mostly provided by family, friends, neighbours, or elderly persons.

It is difficult to compare the present results with other studies because different instruments were used, the recruitment of subjects was organized in different ways, and participating refugees had experienced different traumas in their country of origin. However, in accordance with present results, in general it appears that PTSD, depression, anxiety, fear of repatriation, barriers to work, and hopelessness are major problems for refugees [5,28,29,41–45]. Mollica and coworkers found about the same percentage of PTSD but a much higher percentage of depression among a large group of Khmer adults [29]. These problems are worse when refugees have experienced personal traumatic experiences such as being tortured, witnessing murders, and lives being threatened e.g. [30,39,41]. A study in Sri Lanka revealed the same picture for persons who had experienced war stresses but had not left their country [42].

Women did not mention sexual harassment as a camp problem. However, respondents mentioned that children married and had sex at an earlier age than was custom in Sri Lanka. This was against the wishes of their parents. The parents blamed the housing facilities that caused families to live together in a small space where privacy was extremely limited. This problem was not labelled by the women as sexual harassment. This may have several reasons. First, the interviewers did not specifically ask about sexual harassment. Second, women might have been afraid to mention sexual harassment if this was a continuing problem in the camps. Another reason might be that not all refugee women were interviewed by an interviewer of their own gender. Although interviewers tried to talk to persons of their own gender, this was not always possible. However, women who were interviewed by a female interviewer also did not mention sexual harassment. Still, an influence of gender may not be excluded.

Fleeing to a Western country seems to add problems related to assimilation, culture shock, and language problems [5,6]. In addition, the refugees that do flee and get asylum in Western countries are often persons with severe personal trauma, because these countries apply the strict definition of a refugee. However, whether the problems in refugees who fled to a Western country are really worse still needs to be examined. The present study also showed that respondents who had experienced personal trauma scored higher on PTSD. From the few studies conducted among adults who lived in refugee camps, a grim picture emerges. For instance, research in a Cambodian refugee camp revealed that more than 85% of the refugees suffered from PTSD following an intense trauma. Furthermore, it was shown that psychosomatic symptoms related to depression coincided with PTSD, and that these effects could extend over a long period of time [28]. In general, 40 to 50% of the refugees suffer from PTSD [41]. Rangaraj [46] concluded that refugees who stay in a camp for a long time seem to die internally: outwardly, they have lost everything; inwardly, they are listless, dispirited, and despondent. The results from the present study also indicate major problems for the Tamil refugees, from whom most lived in a refugee camp for more than four years.

The fact that most respondents in the present study already lived in a refugee camp for several years is a difficulty in diagnosing PTSD. According to the ICD-10 definition of PTSD, the onset must be within six months of the traumatic event(s). However, in the present study this could not be verified. One effect that this might have is that the disorder is underreported in the sense that a higher percentage of respondents might have fulfilled the PTSD criteria in the period of six months following their arrival in India. A number of refugees/displaced persons might have worked through their trauma in the period thereafter. However, the present interest was in mental health problems. Persons meeting all other criteria of PTSD have mental health problems and therefore are of interest in this study.

Another restriction to this study is that the group of respondents is a selected group. The Tamil organization asked persons within the camps to cooperate in the study. Because the Indian Government nor any other official institute was involved in the study, recruitment for this study had to be done carefully and low profile, making the best of it. Therefore, the results might not be representative for the total Tamil population living in refugee camps in South India. Consequently, whether the present results actually underestimate or overestimate existing problems can not be determined. However, respondents came from many different camps and in general the information about camp life and the problems in Sri Lanka formed a coherent story.

Other methodological shortcomings of the present study concern a lack of a comparison group and a validity check. Because it was impossible to go to the North-Western part of Sri Lanka to interview Tamils, no comparison group was used in the present study. Other potential comparison groups, for instance, Indians living in the areas of the refugee camps, were inadequate due to a different cultural background, different living conditions, and a lack of recent civil war experiences. The absence of a comparison group has some obvious methodological down-sides such as an impossibility to place the present results in perspective. The lack of a validity check of the questionnaires was mainly due to the sample size, a lack of existing norm for inhabitants of Sri Lanka, and the fact that the study population was difficult to contact. In fact, most restrictions in the present study were caused by the fact that the respondents were a convenience sample. Unfortunately, this is inherent to this type of studies.

Because the sequence in which the respondents are asked interview questions or complete the questionnaires may influence answers provided, the interview and questionnaires were alternated. That is, in about half of the cases respondents were interviewed before they completed the questionnaires. The other respondents started with the questionnaires and were interviewed subsequently.

For the refugees the situation in India, the way in which they were treated by the Indian population and the government, had deteriorated since a Tamil had executed Rajiv Gandhi.

A number of refugees/displaced persons mentioned that before the execution the Indian government had been much more helpful and less restrictive to them. In addition, the Indian population had been more kind in earlier times. The more negative attitude of the Indian population also was attributed to the growing of the population which led to lack of water and food. In this sense the Tamil refugees are a political problem.

In general it is important that counselling centres are easily accessible and counsellors have the same cultural background as the refugees. It is known that psycho-education and psycho-social activities are effective tools to alleviate traumatic stress responses [40]. In addition, treatment elements such as psychological structuring of experiences, working on control, reconnecting own experiences to emotions, working on integration and future perspective, and self-help techniques are known to be effective in refugees who have recently experienced (war) trauma [40]. However, the effectiveness of these techniques in refugee populations with prolonged PTSD symptoms remains to be studied.

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